Washington State Department of Social & Health Services

EXTENSION REQUEST FOR HOSPITALIZATION

1. PATIENT IDENTIFICATION CODE (PIC)	2. DATE
3. PATIENT NAME	

4. HOSPITAL NAME	5. CITY

6. PRINCIPLE DIAGNOSIS

7. OTHER DIAGNOSES

8. SURGERIES

9. Principle diagnostic code:	10. Maximum days allowed per code (Length Of Stay):

11. REASON FOR EXTENSION REQUEST

12. ADMITTING DATE	13. DISCHARGE DATE	14. INTERIM DATES

15. Total number of days in the hospital:	16. Number of additional days requested:

17. REVIEWER SIGNATURE   SIGNATURE DATE

FOR DSHS USE ONLY

Professional Activity Study (PAS) days approved: _____ acute, _____ administrative; _____ denied.

AUTHORIZING SIGNATURE   DATE REVIEWED   REFERENCE NUMBER

COMMENTS

DSHS 13-077 (REV. 05/1998)

Send this form to: MEDICAL ASSISTANCE ADMINISTRATION (MAA)
CLINICAL CONSULTATION TEAM (CCT)
PO BOX 45506
OLYMPIA WA 98504-5506

DISTRIBUTION: White and Yellow - MHCRA   Pink - Hospital Holding

The hospital or attending physician is responsible for completing this extension request. In order to process extensions, an adequate understanding of what is transpiring and the chain of events involved is necessary. Also, a clear documentation of the requirement for acute hospital care is required.

1. PATIENT IDENTIFICATION CODE (PIC): This code can be obtained from the medical identification card. It is a fourteen-digit figure. A birthday of January 10, 1960, for John A. Jones would appear as "**JA 011060 JONES A**".

2. DATE: Write the date when the form is **initiated**.

3. PATIENT NAME: Self-explanatory.

4. HOSPITAL NAME: Self-explanatory.

5. CITY: The city in which the hospital is located.

6. PRINCIPLE DIAGNOSIS: Use the principle diagnosis covering the initial or primary stay.

7. OTHER DIAGNOSES: List any other diagnosis codes that will be included on the Medicaid billing form UB-92.

8. SURGERIES: This is defined as significant surgical procedures, invasive in nature, that would have an effect on the Length of Stay (LOS).

9. PRINCIPLE DIAGNOSTIC CODE: This is the International Classification of Diseases - 9th Edition (ICD-9) code for principle diagnosis.

10. MAXIMUM DAYS ALLOWED PER CODE (LOS): Indicate the maximum number of days allowed according to the **75th percentile** of the Professional Activity Study (PAS) code as listed in Length of Stay (LOS) by Diagnosis - Western Region.

11. REASON FOR EXTENSION REQUEST: Provide a complete justification of the reason for the extension request. The approving authority makes a decision based on information provided in this section and on any documentation attached.

12. ADMITTING DATE: The date the patient was admitted into the hospital.

13. DISCHARGE DATE: The date the patient was discharged from the hospital.

14. INTERIM DATES: Interim dates are dates being billed if the patient is still in the hospital.

15. TOTAL NUMBER OF DAYS IN THE HOSPITAL: This is the total number of days included on the PAS request (from the admit date to the discharge date).

16. NUMBER OF ADDITIONAL DAYS REQUESTED: Indicate the exact number of additional days being requested insofar as professional assessment can be made.

17. REVIEWER SIGNATURE: The person completing this form signs and dates the form here.

Once completed, send the white and yellow copies of this form to:

MEDICAL ASSISTANCE ADMINISTRATION (MAA)
CLINICAL CONSULTATION TEAM (CCT)
PO BOX 45506
OLYMPIA WA 98504-5506

Keep the pink copy for your records.

The approving authority will complete this form and return the white copy to the hospital to include with the billing. **It is important that the form be attached to the hospital billing form in order to facilitate the payment process.**